



Carlos A. Gimenez, Mayor
www.miamidade.gov

**Public Housing and Community Development
Miami-Dade Housing Choice Voucher Program**

P.O. Box 521750
Miami, FL 33152-1750
TTD/TTY Florida Relay Service
1-800-955-8771 or Dial 771

Customer Service Number: 305-403-3222/ Fax: 786-358-5893

**Si necesita ayuda con este formulario, llame al 305-403-3222
Si w bezwen asistans ak fòm sa a, tanpri rele 305-403-3222**

INFORMAL HEARING/REVIEW REQUEST FORM

Use this form if you have been recommended for termination and are requesting hearing or review. Complete this form and submit it to the address listed below.

Last Name: _____ First Name: _____ MI: _____
Entity ID#: _____ Last four digits of Social Security Number: _____
Current Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

PLEASE ATTACH A COPY OF YOUR INTENT TO TERMINATE (ITT) NOTICE. IF YOU DO NOT HAVE AN ITT PLEASE EXPLAIN YOUR REASON FOR REQUESTING A HEARING. _____

Mail to: Miami-Dade HCV Program OR Drop-off at: Miami-Dade HCV Program
P.O. Box 521750 7400 Corporate Center Drive (NW 19th Street)
Miami, FL 33152 Miami, FL 33126

The date, time, and location of the hearing or review will be mailed to you after MDHCV receives and evaluates your written request.

Your Signature _____
Date

- Check this box if you require a reasonable accommodation to assist you with the hearing/review process. You will be contacted by MDHCV concerning your request.
- Check this box if you will be represented by an attorney.

You must notify MDHCV at 305.403.3222 at least 24 hours prior to the scheduled time of the review or hearing, if you are unable to attend. MDHCV may allow up to one rescheduled date/time for good cause. If you have questions or need assistance to translate this document, please contact 305.403.3222 between 8:00am and 5:00 pm, Monday through Friday.

Be advised, you have the right to:

- *Request a reasonable accommodation to assist you with; my aspect of the hearing/review process because of your disability, or if you need a sign language interpreter or material in accessible format. Indicate above if such an accommodation is needed or call the MDHCV office five (5) days prior to the hearing/review.*
- *Review any MDHCV documents prior to the hearing. Including your file directly related to the MDHCV's decision. To review your file and/or obtain copies of your file, please submit a written request to the address above. There is a cost or \$0.15 per page or \$0.20 for legal or double sided copies.*
- *Request a copy of or review the criminal record if the termination is based on criminal activity. To review this record, submit a request to the address above. You will be contacted for an appointment to review the documents.*
- *Be represented at the hearing/review by a lawyer or other representative of your choice.*
- *Request an explanation of the reason for MDHCV's decision at the hearing/review.*
- *Present written or oral objections to MDHCV's decision at the hearing/review.*

Please be aware that failure to attend the scheduled hearing at the time indicated will result in termination of the program.

